# History and Physical Exam Form

Name: ______________________ Date: ______________________

ISN: ________________________

VS: BP:
Pulse:
Resp:
Temp:
Height:
Weight:

DOB: _________ AGE: _________

Gender: Male / Female

Complaint: Acute:

Chronic:

PMH: DM HTN STD TB
Hosp:
Surg:

Medications:

Allergies:

SocHx: Tobacco Y / N
_____PPDx_____yrs
EtOH

ROS: HEENT:
CV:
PULM:
GI:
GU:
OB/GYN:
MS:
NEURO:
DERM:
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
_____mm

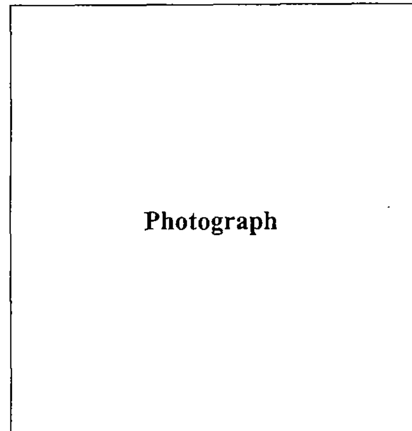
Immunizations: (given at this time)

MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

| | |
|---|---|
| HEENT: | Normal / Abnormal |
| CV: | Normal / Abnormal |
| PULM: | Normal / Abnormal |
| GI: | Normal / Abnormal |
| GU: | Normal / Abnormal |
| OB/GYN: | Normal / Abnormal / NA |
| MS: | Normal / Abnormal |
| NEURO: | Normal / Abnormal |
| DERM: | Normal / Abnormal |
| ENDO: | Normal / Abnormal |
| PSYCH: | Normal / Abnormal |




Comments / Findings:

Impression: ______________________________________________

______________________________________________

Plan: ______________________________________________

Provider Signature: Printed Name / Stamp:



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